MDR Tracking Number: M5-04-3599-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on June 21, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The therapeutic exercises, office visits with manipulations, chiropractic manipulative treatment rendered on 7/2/03 through 11/20/03 was found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 8, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Rationale
7/18/03	99080-73	$20.00	$0.00	V	$15.00	Review of the carriers EOB dated 8/26/03 and 3/4/04 revealed the carrier has denied CPT code 99080-73 as "V-Unnecessary medical treatment with a peer review." However, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount of $30.00.
8/8/03	99080-73	$20.00	$0.00	V	$15.00	
TOTAL		$40.00	$0.00		$30.00	Reimbursement is recommended in the amount of $30.00.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 7/2/03 through 11/20/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

August 26, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3599-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 33 year-old male who sustained a work related injury on ------. The patient reported that while at work he injured his right hand when he attempted to transfer a box. A MRI of the right wrist performed on 5/16/03 indicated partial incomplete tear involving the scapholunate ligament, intact remaining flexor and extensor tendons, and a small 3-mm cyst indentified in the capitate bone. The diagnoses for this patient have included right wrist sprain/strain and right wrist tenosynovitis. Treatment for this patient's condition has included ultrasound, electrical stimulation, hot/cold packs, and manipulation.

Requested Services

Therapeutic exercises, level III office visits w/manipulation, and chiropractic manipulative treatment from 7/2/03 through 11/20/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:
1. MRI report 5/16/03
2. Daily Treatment Log 5/2/03 – 11/20/03
3. FCE 8/4/03, 7/17/03

Documents Submitted by Respondent:
1. Chiropractic Modality Review 6/23/03
2. X-ray right wrist report 4/17/033
3. Office notes 5/1/03 – 11/20/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 33 year-old male who sustained a work related injury to his right hand on ------. The ------ chiropractor reviewer also noted that the treatment for this patient's condition had included ultrasound, electrical stimulation, hot/cold packs, and manipulation. The ------ chiropractor reviewer indicated that the documentation provided showed that the patient made steady progress with the treatment rendered. The ------ chiropractor reviewer noted that an FCE performed on 8/4/03 showed the patient to be able to return to work without restrictions. The ------ chiropractor reviewer also noted that the patient was evaluated twice after returning to work and was released from active care. The ------ chiropractor reviewer explained that the treatment this patient received was appropriate and medically necessary. The ------ chiropractor reviewer also explained that treatment this patient received followed the path of correction of function, eliminated this patient's pain and returned him to work. Therefore, the ------ chiropractor consultant concluded that the therapeutic exercises, level III office visits w/manipulation, and chiropractic manipulative treatment from 7/2/03 through 11/20/03 were medically necessary to treat this patient's condition.

Sincerely,